Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: COMBINED CHIROPRACTIC SERVICES & REHABILITATION, INC. 88 BRIGGS AVENUE SUITE 245 SAN ANTONIO TX 78224	MFDR Tracking #: M4-11-0781-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Box #: MITSUI SUMITOMO INSURANCE USA Box #: 19	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary along with the DWC060 request; however the *Table of Disputed Services* rationale for increased reimbursement states: "Medical necessity. Per Auth. Approved #711113260."

Amount in Dispute: $263.64

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This involves DOS 08/12/10 for three sessions of PT. The reimbursement was denied as the services were not medically necessary. The Requestor provided evidence of preauthorization (#711113260), but his authorization for nine sessions of PT to be completed before 08/20/2010 had already been completed by DOS 08/04/10, 08/05/10 and 08/10/10, and therefore the services in question herein exceeded the preauthorized amount of PT. *See* enclosed documentation."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Medical Fee Guideline Reimbursement	Amount in Dispute	Amount Due
8/12/2010	99212-25	N/A	$56.91	$0.00
8/12/2010	97110-GP	$167.46	$167.48	$167.46
8/12/2010	97140-GP-59	$39.25	$39.25	$39.25
			Total Due:	$206.71

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated 8/23/2010
   - 50, GP, T13-Service not deemed "medically necessary" by payer, service delivered under op PT care plan, med necessity denial. Appeal within 11 mos of DOS
   - 50, 59, GP, T13- Service not deemed "medically necessary" by payer, service delivered under op PT care plan, med necessity denial. Appeal within 11 mos of DOS

Issues

1. Did the requestor obtain preauthorization for the physical therapy services in accordance with 134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent states in the position statement states in part: "…authorization for nine sessions of PT to be completed before 08/20/10 had already been completed by DOS 08/04/10, 08/05/10 and 08/10/10, and therefore the services in question herein exceeded the preauthorized amount of PT. *See* enclosed documentation." Review of the documentation submitted by the requestor consisted of a position summary, a copy of the DWC060 and a copy of a CMS-1500 for date of service 8/11/2010. Insufficient documentation was submitted to support that the requestor has exceeded the 9 sessions of physical therapy. Therefore, medical fee dispute resolution will proceed with the audit based on the denial reasons presented on the EOB.
2. Pursuant to rule 134.600 (p)(5)(A), states: "Non-emergency health care requiring preauthorization includes: physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
   (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning;
   (iii) Orthotics/Prosthetics Management;
   (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code;
3. The requestor submitted a preauthorization letter issued by Corvel dated 7/21/2010 which indicates that approval was granted for post op PT 3xwk x 3wks—9 visits (97110, 97140).
4. The insurance carrier denied preauthorized physical therapy services due to unnecessary medical. Sec. 413.014 (e) states: "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service." The requestor seeks reimbursement for CPT code 97110 and CPT code 97140 both codes were preauthorized by the insurance carrier and therefore, the requestor is entitled to reimbursement in the amount of $206.71.
5. The requestor is requesting reimbursement for CPT code 99212; however review of the CMS-1500 and the EOB included with the dispute does not contain CPT code 99212 on the bill or the audit EOB. No documentation was submitted to support that the insurance carrier was billed and audited CPT code 99212. Therefore, this CPT code is not eligible for review and reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $206.71.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $206.71 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	February 11, 2011 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.